Attachment F: Applicant Guide

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Stages of Community Readiness

Western Regional Center for the Application of Prevention Technologies

(Excerpt from *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools,* l997, National Institute of Drug Abuse, p. 13-15)

Though extensive research on community development and substance abuse prevention efforts, Oetting and colleagues (Oetting et al. 1995*)* have identified nine stages of readiness through which communities develop: the higher the stage of development, the greater the degree of readiness, The following are descriptions of the nine stages and the characteristics of communities at each stage:

Stage 1: Community Tolerance/No Knowledge

Community norms actively tolerate or encourage the behavior, although the behavior may be expected of one group and not another (e.g., by gender, race, social class, or age). The behavior, when occurring in the appropriate social context, is viewed as acceptable or as part of community norm. Those who do not engage in the behavior may be tolerated, but might be viewed as somewhat deviant.

Stage 2: Denial

There is usually recognition that the behavior is or can be a problem. Community norms usually 'would not approve of the behavior, but there is little or no recognition that this might be a local problem. If there is some idea that it is a problem, there is a feeling that nothing needs to be done about this locally, or that nothing can be done about it.

Stage 3: Vague Awareness

There is a general belief that there is a local problem and that something ought to be done about it. Knowledge about local problems tends to be stereotypical and vague, or linked only to a specific incident or two. There is no immediate motivation to do anything. No identifiable leadership exists, or leadership lacks energy or motivation.

Stage 4: Preplanning

There is clear recognition that there is a local problem and that something should be done about it. There is general information about local problems, but ideas about etiology, or risk factors tend to be stereotyped. There are identifiable leaders, and there may be a committee, but no real planning.

Stage5: Preparation

Planning is going on and focuses on practical details. There is general information about local problems and about the pros and cons of prevention programs, but it may not be based on formally collected data. Leadership is active and energetic. The program may have started on a trial basis. Funding is being actively sought or has been committed.

Stage 6: Initiation

Enough information is available to justify a prevention program, but knowledge of risk factors is likely to be stereotyped. A program has been started and is running, but it is still on trial. Staffs are in training or just finished with training. There may be great enthusiasm because limitations and problems have not yet been experienced.

Stage 7: Institutionalization/Stabilization

One or two programs are running, supported by administration, and accepted as a routine and valuable activity. Staff are trained and experienced. There is little perceived need for change or expansion. Limitations may be known, but there is not much sense that the limitations suggest a need for change. There may be some form of routine tracking of prevalence. There is not necessarily permanent funding, but there is established funding that allows the program the opportunity to implement its action plan.

Stage 8: Confirmation/Expansion

Standard programs are viewed as valuable and authorize support expanding or improving programs. New programs are being planned or tried out in order to reach more people, those thought to be more at risk or different demographic groups. Funds for new programs are being sought or committed. Data are obtained regularly on extent of local problems and efforts are made to assess risk factors and cause of the problem.

Stage 9: Professionalization

Detailed and sophisticated knowledge of prevalence, risk factors, and etiology exists. Some programs may be aimed at populations, while others are targeted at specific risk factors and/or at-risk groups. Highly trained staffs are running programs, authorities are supportive, and community involvement is high. Effective evaluation is used to test and modify programs.

Oetting and colleagues (Oetting et al, 1995) have found that as communities achieve successively higher stages, they realize greater improvement in their degree of readiness. Therefore, to increase a community's readiness for prevention programming and thereby improve the likelihood that a prevention effort will succeed, it is important to give careful consideration to these nine stages of community readiness development during the process of conducting an objective assessment of community readiness.

Oetting, E.R.; Donnermeyer, J.J.; Plested, B.A.; Edwards, R.W.; Kellly, K.; and Beauvais, F. Assessing community readiness for prevention. International Journal of Addiction, 30(6):659-683, 1995

For more information and tools on community readiness, the National Institute on Drug Abuse has available, "Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools." To obtain a copy, contact National Technical Information Services at (800) 553-6847 (publication number PB#97-209605). This book is part of a 5-book packet, which costs $83 plus $5 handling.

Risk and Protective Factor Definitions
For the Community, Family, School, and Individual Domains

Risk Factors		
COMMUNITY	**Low Neighborhood Attachment**	Defined as a lack of connection to the community. Low levels of bonding to the neighborhood are related to higher levels of juvenile crime and drug selling.
	Community Disorganization	Defined as the prevalence of crime, violence, and delinquency in the neighborhood. Research has shown that neighborhoods with high population density, lack of public surveillance, physical deterioration, and high rates of adult crime also have higher rates of juvenile crime and drug selling.
	Transition & Mobility	Defined as amount of movement from one community or school to another. Neighborhoods with high rates of residential mobility have been shown to have higher rates of juvenile crime and drug selling, while children who experience frequent residential moves and stressful life transitions have been shown to have higher risk for school failure, delinquency, and drug use.
	Exposure to Community Alcohol, Tobacco, and other Drug (ATOD) use	Defined as frequent exposure to ATOD use by people in one's neighborhood or school. Frequent exposure to ATOD use influences normative beliefs and understanding of how to engage in the behavior and, thus, increases likelihood of ATOD use.
	Laws & Norms Favorable to Drug Use	Defined as the attitudes and policies a community holds about drug use and crime. Research has shown that legal restrictions on alcohol and tobacco use, such as raising the legal drinking age, restricting smoking in public places, and increasing taxation have been followed by decreases in consumption. Moreover, national surveys of high school seniors have shown that shifts in normative attitudes toward drug use have preceded changes in prevalence or use.
	Perceived Availability of Drugs & Handguns	Defined as the perceived ease in obtaining drugs and firearms for adolescents. The availability of cigarettes, alcohol, marijuana, and other illegal drugs has been related to the use of these substances by adolescents. Availability of handguns is also related to a higher risk of crime by adolescents.
	Ability to Purchase Alcohol or Tobacco	Defined as whether or not a student has been able to purchase alcohol and/or tobacco from a store employee, a bar, or a restaurant. Corresponding with perceived availability, opportunities to purchase alcohol and tobacco have been related to use of these substances by adolescents.
	Protective Factors	
	Community Opportunities for Positive Involvement	Defined as opportunities to engage in prosocial activities in the community such as sports or adult-supervised clubs. When opportunities are available In a community for positive participation, children are less likely to engage in substance use and other problem behaviors.
	Community Rewards for Positive Involvement	Defined as community encouragement for adolescents engaging in positive activities, Rewards for positive participation in activities help children bond to the community, thus lowering their risk for substance use,
Risk Factors		
FAMILY	**Poor Family Supervision**	Defined as a lack of clear expectations for behavior and a failure of parents to monitor their children. Parents' failure to provide clear expectations and to monitor their children's behavior makes It more likely that Their children will engage in drug use whether or not there are family drug problems.
	Family Conflict	Defined as the degree to which family members fight or argue. Children raised In families high in conflict, whether or not the child is directly involved in the conflict, appear at risk for both delinquency and drug use
	Lack of Parental Sanctions for ATOD Use	Defined as a low probability that parents will sanction their children for .ATOD use. Parents' failure to clearly communicate to their children that their children would be in trouble if caught using alcohol, tobacco, or other drugs places children at higher risk for substance use.
	Parental Attitudes Favorable Toward ATOD Use	Defined as parental attitudes approving of young people's ATOD use. In families where parents are tolerant of children's use, children are more likely to become drug abusers during adolescence.
	Exposure t_0 Family ATOD Use	Defined as a high degree of exposure to parents' ATOD use. In families where parents use illegal drugs or are heavy users of alcohol, children are more likely to become drug abusers during adolescence. The risk is further increased if parents involve children in their own substance-using behavior- for example, asking the child to light the parent's cigarette or to get the parent a beer from the refrigerator.
	Parental Attitudes Favorable Toward Anti-Social Behavior (ASB)	Defined as parental attitudes excusing children for breaking the laws. In families where parents are tolerant of antisocial behavior, children are more likely to engage in antisocial behavior.
	Family (Sibling) History of ASB	Defined as high ASB prevalence among brothers and sisters. When children are raised in a family with a history of problem behaviors, the children are more likely to engage In these behaviors.

	Protective Factors	
	Family Attachment	Defined as feeling connected to and loved by one's family. Young people who feel that they are a valued part it of their family are less likely to engage in substance use and other problem behaviors.
	Family Opportunities for Positive Involvement	Defined as opportunities for positive social interaction with parents. Young people who are exposed to more opportunities to participate meaningfully in the responsibilities and activities of the family are less likely to engage in drug use and other problem behaviors.
	Family Rewards for Positive Involvement	Defined as positive experiences with parental figures. When family members praise, encourage, and attend to their children's accomplishment, children are less likely to engage in substance use and ASB.
SCHOOL	**Risk Factors**	
	Low School Commitment	Defined as the student's inability to see the role of a student as a viable one. Factors such as disliking school and perceiving the course work as irrelevant are positively related to drug use
	Poor Academic Performance	Defined as poor performance in school. Beginning in the late elementary grades (grades 4-6), academic failure increases the risk of drug abuse and delinquency
	Protective Factors	
	School Opportunities for Positive Involvement	Defined as opportunities to become involved in school activities. When young people are given more opportunities to participate meaningfully in important activities at school, they are less likely to engage in drug use or problem behaviors.
	School Rewards for Positive	Defined as positive feedback by school personnel for student achievement. When young people are recognized and rewarded for their contributions at school, they are less likely to be involved in substance use and other problem behaviors.
PEER-INDIVIUAL	**Risk Factors**	
	Early Initiation of Problem Behaviors	Defined as early substance use and early onset of problem behaviors. The earlier the onset of any drug use, the greater the involvement in other drug use, Onset of drug use prior to the age of 15 is a consistent predictor of drug abuse; later age of onset of drug use has been shown to predict lower drug involvement and a greater probability of discontinuation of use
	Favorable Attitudes Toward ATOD Use	Defined as perceptions that it is not wrong for young people to engage in ATOD use. Initiation of use of any substance is preceded by values favorable to its use, During the elementary school years, most children express anti-drug, anti-crime, and prosocial attitudes and have difficulty imagining why people use drugs. However, in middle school, as more youths are exposed to others who use drugs, their attitudes often shift toward greater acceptance of these behaviors. Youths who express positive attitudes toward drug use are at higher risk for subsequent drug use.
	Low Perceived Risk of ATOD Use	Defined as perceived harmfulness associated with ATOD use. Young people who do not perceive drug use to be risky are far more likely to engage in drug use.
	Antisocial Behaviors (ASBs)	Defined as engaging in problem behaviors such as violence and delinquency
	Favorable Attitudes Toward ASB	Defined as a student's acceptance of drug use, criminal activity, violent behavior, or ignorance of rules, Young people who accept or condone antisocial behavior are more likely to engage in a variety of problem behaviors, including drug use.
	Friends' ATOD Use	Defined as having several close friends who engage in ATOD use. Peer drug use has consistently been found to be among the strongest predictors of substance use among youths even when young people come from well-managed families and do not experience other risk factors.
	Interaction with Antisocial Peers	Defined as having several close friends who engage in problem behaviors, Young people who associate with peers who engage in problem behaviors are at higher risk for engaging in antisocial behavior themselves.
	Rewards for Antisocial Involvement	Defined as having friends who approve of ATOD use and who are ignorant of laws and rules. Young people who receive rewards for their ASB are at higher risk for engaging further in ASB and ATOD use.
	Rebelliousness	Defined as not being bound by rules and taking an active rebellious stance toward society. Young people who do not feel like part of society, are not bound by rules, do not believe in trying to be successful or responsible, or who take an active rebellious stance toward society, are at higher risk of abusing drugs.
	Sensation Seeking	Defined as having a high need for sensation or arousal experiences. Young people with a high need for arousal have increased risk for participating in ATOD use and other problem behaviors
	Gang Involvement	Defined as the degree of involvement in gangs or with gang members. Gang involvement often increases youth exposure to ATOD use and ASS, which puts them at greater risk for engaging in similar behaviors

Depression	Defined as signs of depression or lack of self-worth. Lack of self-worth is often associated with ATOD use.
Protective Factors	
Peer Disapproval of ATOD and Handguns	Defined as student perceptions that his or her close friends would disapprove of him or her using substances Use and Handguns or carrying handguns. Peer pressure is a strong factor influencing adolescent behavior, and peer pressure not to use alcohol, tobacco, and other drugs is a very powerful deterrence.
Religiosity	Defined as perceiving oneself to be religious and enjoying religious activities. Young people who regularly attend religious services are less likely to engage in problem behaviors.
Belief in the Moral Order	Defined as beliefs that one is bound by societal rules. Young people who have a belief in what is "right" and 'wrong" are less likely to use drugs.
Educational Aspirations	Defined as aspirations for continuing on to and graduating from college. National surveys of high school seniors have shown that ATOD use is significantly lower among students who expect to attend and graduate from college than among those who do not.

IOM Classification of Prevention Services

The Institute of Medicine (1994) proposed a new framework for classifying prevention. This framework is organized for diverse targeted audiences. The classification is based on the degree to which any individual person is identified as an individual at risk for substance abuse.

The at-risk determination is based on a combination of the risk and protective factors associated with alcohol and other drug problems.

Classifications for Prevention Actions and Program Services:

Prevention Actions	Target Populations	Characteristics of Selective Prevention Actions	Examples of Prevention for Substance Abuse May Include
UNIVERSAL: Reaches the entire populations in a pre-determined geographical area.	➢ General population is targeted without regard to individual risk factors	➢ Designed to reach very large audience ➢ Program provided to everyone in the population	➢ Substance abuse education for all children within a school district. ➢ Media and public awareness campaigns within a specific area. ➢ Social policy changes such as reducing availability of alcohol by reducing the number of liquor outlets in a geographic area.
SELECTIVE: Targets subgroups of the general population that are determined to be at higher risk for substance abuse	➢ Targets residents who are recruited to participate in the prevention effort because of the entire subgroups' profile of high risk	➢ Applies knowledge of specific risk factors within the targeted subgroup to have programs, which address specific risk reduction objectives. ➢ Does not necessarily assess the individual or personal risk of members of the subgroup.	➢ Special clubs and groups for children of alcoholics ➢ Rites of passage programs for at-risk males ➢ Skill training ➢ Programs for young children of substance-abusing parents
INDICATED Targets individuals identified as experiencing early signs of substance abuse and other related problem behaviors.	➢ Targets individuals who have not reached the point where in clinical diagnosis of substance abuse can be made. ➢ Targets individuals who may have demonstrated: o School failure o Interpersonal social problems o Delinquency and other antisocial behaviors o Depression and suicidal behavior	➢ Precise assessment of an individual's personal risk ➢ Assessment of level of related problem behaviors ➢ Extensive and highly intensive ➢ Operate for longer periods of time, at greater frequency of contact ➢ Require sustained effort of participants.	➢ Programs for school age children experiencing problem behaviors to include tutoring, mentoring, decision-making skill building, leadership ➢ Parenting education and support programs ➢ Case management ➢ After-school programs (recreational and educational)

Guide for Selection of Science-Based Prevention Actions and Program Services

TYPE	PREVENTION ACTIONS AND PROGRAM SERVICES	CRITERIA FOR PREVENTION ACTIONS AND PROGRAM SERVICES
Type 1	The prevention program or prevention model or principle has been identified or recognized publicly, received awards, honors or mentions.	➢ A panel of persons qualified in both the fields of substance abuse prevention and research methods must have reviewed and critiqued the proposed program or model ➢ The panel must have determined that the quality of implementation of the proposed program and the overall quality of the research plan and analysis will produce scientifically defensible results.
Type 2	The prevention program or prevention model or principle has appeared in professional publication or journal without being reviewed, critiqued, and judged (refereed) by professional peers. This type separates programs or principles found in professional publications from those found in professional journals.	➢ *Professional publications*: Prevention program information that appears only in such professional publications should be viewed as having merit, but should not be viewed as scientific support for a particular program model or principle. ➢ *Professional journals*: Information that appears in professional journals generally offers better information about the credibility of the information. It is important to distinguish between refereed (peer/expert reviewed) journals and journals which do not have such level of review.*
Type 3	The prevention program's source documents have undergone thorough scrutiny in an expert peer review process for the quality of implementation and evaluation methods or the paper has appeared in a peer-reviewed refereed journal.	➢ Report of study methods and findings appear in a peer reviewed journal. ➢ Complete source documents have been scrutinized. All dosage information and data collection process are made plain and all analyses are laid out for review. ➢ The program is rated as producing credible information regarding principles of prevention and is judged to have potential as an effective model for prevention.
Type 4	The programs or principles have undergone an expert/peer consensus process in the form of a qualitative or quantitative meta-analysis.**	➢ Multiple studies are reviewed and coded for the quality of methodological rigor and findings. ➢ A broad array of program interventions and evaluation strategies has built confidence that the principles are real and solidly defensible and are related casualty to the observed effects.
Type 5	Replications of program/principles have appeared in several refereed professional journals.	➢ Best evidence of the effectiveness of a program's model's strong scientific basis is that it can be replicated across venues and populations, demonstrating credibility, utility, and general applications to other populations. ➢ Programs can either be replicated exactly or principles derived from programs can be replicated conceptually. Exact replications apply the original program to a new population or in a new venue. Conceptual replications adapt the program maintaining its key principles but modifying specific activities. ➢ Evidence of replications is found in refereed* journal articles or meta-analytic** efforts. ➢ Successful replication of an effective program model provides support for the principles upon which the program is based and for the intervention strategy as a whole.

* Refereed (peer/expert review) journal: Expert/peer consensus reached regarding merits of the work in the journal which is the minimum requirement for saying the information contained on the prevention program is scientifically defensible.

Non-refereed journal: Information should be viewed like information in other professional publications and newsletters as suggestive but without substantiation.

**Meta-analysis: The weaving together of several strands of research.

Qualitative Evaluation: results gathered from focus groups, interviews, expert estimations, and observations.

Quantitative Evaluation: results derived from measurement of time, activities, and amount of service based on a selected sample from a larger population.

Prevention Strategies

A. Working Definitions

Prevention and early intervention. Most of ***primary prevention*** focuses on individuals or populations before the onset of harmful involvement with alcohol or drugs. However, some prevention strategies (such as laws and policies) are applicable to all persons in an environment, regardless of their level of current use. For example, the rate of excise taxes on tobacco and alcohol can affect consumption and consequent problems among users, as well as prevent initiation among nonusers, especially youth (e.g., Hu et al. 1995; Manley et al. 1994). *Early intervention* usually involves identification of the onset of use or early stage problems in individuals or groups who do not yet require treatment. For the purposes of this document, "prevention" includes both primary prevention and early intervention,

Prevention efforts or approaches. As used in this document, prevention efforts or approaches are intentional attempts to reduce substance abuse problems before they start, through a variety of strategies. Examples include a national drug policy; a coordinated, community wide coalition; a school curriculum focusing on substance abuse; a parenting skills manual; a media campaign against smoking; constraints on alcoholic beverage sales to minors; laws regarding access to cigarette vending machines; a "rites of passage" program emphasizing traditional cultural values and practices; and drug testing in the workplace.

B. Prevention Strategies

Prevention strategies have been categorized in a variety of different ways. SAMIHSA] CSAP promotes the following six strategies':

Information dissemination: This strategy provides awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

Education: This strategy involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator, facilitator, and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.

Alternatives: This strategy provides for the participation of target populations in activities that exclude substance use. The assumption is that constructive and healthy activities offset the attraction to-or otherwise meet the needs usually filled by-alcohol and drugs and would, therefore, minimize or obviate resort to the latter.
Problem identification: and referral: This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

Community-based process: This strategy aims to enhance the ability of the community to provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.

Environmental: This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two sub categories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.

Proposed CSAP Core Measures

Capacity Domain	Process Domain	Outcome Domain
Percentage of prevention programs that are evaluated not less than every 2 years	**Measurement** Name of Science-Based program	**Measurement** **Individual** Favorable attitudes toward use/disapproval of drug use
Percentage of sub-States entities capable of reporting data electronically to the State ATOD office	Program's level of rigor (CSAP definition)	Perceived harm/risk of drug use
Percentage of programs that have operationalized MDS 3.1 (or similar) system	Type of prevention program (universal,/selected/indicated)	**Peer** Perceived peer ATOD use
Percentage of prevention practitioners who are professionally credentialed	Client demographic data (age/gender/race/ethnicity)	**Family** Perceived parental attitudes toward youth ATOD use
	Number of sessions	Parent supervision and family management
	Census at each session	**School** School bonding/commitment
	Frequency of reporting	**Community** Perceived availability of drugs and handguns
	Reporting format (paper-based/electronic)	**Environment** Community Norms

Excerpted from
Alcohol and Drug Abuse Division, Request for Proposals
Section 2, General Requirements:

'The APPLICANT shall incorporate best practices/evidence-based practices in any substance abuse service. **Best practices/evidence-based practices are defined as a body of contemporaneous empirical research findings that produce the most efficacious outcomes for persons with substance abuse problems, has literature to support the practices, is supported by national consensus, has a system for implementing and maintaining program integrity, and conformance to professional standards.** For best practices in specific areas of substance abuse, the APPLICANT may consult the Substance Abuse and Mental Health Services Administration's (SAMHSA) **Treatment Improvement Protocol Series (TIPS)**, the National Institute on Drug Abuse's (NIDA) **Principles of Drug Addiction Treatment**, and/or access website resources listed in **Attachment E-7, "Important Website Addresses."'**

Principles of Effective Treatment
National Institute on Drug Abuse (NIDA)

1. **No single treatment is appropriate for all individuals.**
   Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

2. **Treatment needs to be readily available.**
   Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.**
   To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.

4. **An individual's treatment and services plan must be assessed continually and modified periodically to ensure that the plan meets the person's changing needs.**
   A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.**
   The appropriate duration for an individual depends on his her problems and needs. Research indicates that for most patients, the threshold of significant improvements is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.**
   In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.**
   Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a

nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments behavioral treatments and medications can be critically important.

8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.**
   Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.**
   Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addition treatment.

10. **Treatment does not need to be voluntary to be effective.**
    Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

11. **Possible drug use during treatment must be monitored continuously.**
    Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

12. **Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, tuberculosis, and other infectious diseases, and counseling to help individuals modify or change behaviors that place themselves or others at risk of infection.**
    Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.**
    As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

From: Principles of Drug Addiction Treatment; A Research-Based Guide, National Institute on Drug Abuse, National Institutes of Health, October 1999.

Excerpted from
Alcohol and Drug Abuse Division, Request for Proposals
Section 2, General Requirements:

Important Website Addresses

ADAD does not intend this reference to be an exhaustive list of substance abuse treatment Website addresses. APPLICANTS are encouraged to utilize additional resources should more information be needed. Please also note that Website addresses may change periodically.

I. ADAD-Related Regulations.

Code of Federal Regulations (CFR):
http://www.access.gpo.gov/nara/cfr/cfr-table-search.html

- **42 CFR Part 2** -- Confidentiality of Alcohol and Drug Abuse Patient Records
  www.access.gpo.gov/nara/cfr/waisidx_01/42cfrv1_01.html
- **45 CFR Part 96** -- Substance Abuse Prevention and Treatment Block Grants; Interim Final Rule
  www.access.gpo.gov/nara/cfr/waisidx_01/45cfr96_01.html

Public Law (P.L.):
http://www.access.gpo.gov/nara/nara005.html

- **P. L. 102-321 – Subpart II** Block Grants for Prevention and Treatment of Substance Abuse
  http://www.samhsa.gov/centers/csat/content/UBGAS/PLaw102.htm

Hawaii Revised Statutes (HRS):
www.capitol.hawaii.gov/site1/docs/docs.asp?press1=docs

- **Chapter 321, Title 19, HRS –** Department of Health (Index)
  http://www.capitol.hawaii.gov/hrscurrent/vol06_ch321-344/hrs321/hrs_321.htm
- **325-101 HRS** -- Confidentiality of HIV Records
  www.capitol.hawaii.gov/hrscurrent/Vol06_Ch321-344/hrs325/HRS_325-101.htm
- **328K HRS** -- Smoking
  www.capitol.hawaii.gov/hrscurrent/Vol06_Ch321-344/hrs328k/
- **Chapter 334 HRS** – Mental Health, Mental Illness, Drug Addiction, and Alcoholism (Index)
  http://www.capitol.hawaii.gov/hrscurrent/vol06_ch321-344/hrs334/hrs_334.htm
- **577 HRS** -- Adolescents and Confidentiality
  www.capitol.hawaii.gov/hrscurrent/Vol12_Ch501-588/hrs577/

Hawaii Administrative Rules (HAR), Department of Health
http://mano.icsd.hawaii.gov/doh/rules/ADMRULES.html

- **Title 11, Chapter 98 HAR** -- Special Treatment Facility License
  http://mano.icsd.hawaii.gov/doh/rules/11-98.pdf
- **Title 11, Chapter 175 HAR** -- Mental Health and Substance Abuse System
  http://mano.icsd.hawaii.gov/doh/rules/11-175.pdf

II. Government Resources

Hawaii

- **Alcohol and Drug Abuse Division** (ADAD), Department of Health
  http://www.hawaii.gov/health/resource/drug_abuse.html
- **Department of Commerce and Consumer Affairs**
  http://www.hawaii.gov/dcca/breg-seu/related.html

National

- **TIPs (Treatment Improvement Protocols)**
  http://www.kap.samhsa.gov
- **Addiction Technology Transfer Center** (ATTC), The Change Book
  www.nattc.org/thechangebook
- **Center for Substance Abuse Prevention** (CSAP), SAMHSA
  http://www.samhsa.gov/centers/csap/csap.html
- **Center for Substance Abuse Treatment** (CSAT), SAMHSA
  http://www.samhsa.gov/centers/csat/csat.html
- **Drug-Free Workplace Program** -- SAMHSA's model program and resource
  http://workplace.samhsa.gov/frames/frame_starting.htm
- **National Clearinghouse for Alcohol and Drug Information** (NCADI), SAMHSA
  http://www.health.org/
- **National Institute on Alcohol Abuse and Alcoholism** (NIAAA)
  http://www.niaaa.nih.gov/
- **National Institute on Drug Abuse** (NIDA)
  http://www.nida.nih.gov/
- **Substance Abuse and Mental Health Services Administration** (SAMHSA), U.S. Dept. of Health and Human Services
  http://www.samhsa.gov/

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Excerpted from
Alcohol and Drug Abuse Division, Request for Proposals
Section 2, General Requirements:

'The APPLICANT shall incorporate best practices/evidence-based practices in any substance abuse service. **Best practices/evidence-based practices are defined as a body of contemporaneous empirical research findings that produce the most efficacious outcomes for persons with substance abuse problems, has literature to support the practices, is supported by national consensus, has a system for implementing and maintaining program integrity, and conformance to professional standards.** For best practices in specific areas of substance abuse, the APPLICANT may consult the Substance Abuse and Mental Health Services Administration's (SAMHSA) **Treatment Improvement Protocol Series (TIPS)**, the National Institute on Drug Abuse's (NIDA) **Principles of Drug Addiction Treatment**, and/or access website resources listed in **Attachment E-7, "Important Website Addresses."'**

Principles of Effective Treatment
National Institute on Drug Abuse (NIDA)

1. **No single treatment is appropriate for all individuals.**
   Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

2. **Treatment needs to be readily available.**
   Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.**
   To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.

4. **An individual's treatment and services plan must be assessed continually and modified periodically to ensure that the plan meets the person's changing needs.**
   A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.**
   The appropriate duration for an individual depends on his her problems and needs. Research indicates that for most patients, the threshold of significant improvements is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.**
   In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.**
   Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a

nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments behavioral treatments and medications can be critically important.

8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.**
   Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.**
   Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addition treatment.

10. **Treatment does not need to be voluntary to be effective.**
    Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

11. **Possible drug use during treatment must be monitored continuously.**
    Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

12. **Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, tuberculosis, and other infectious diseases, and counseling to help individuals modify or change behaviors that place themselves or others at risk of infection.**
    Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.**
    As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

From: Principles of Drug Addiction Treatment; A Research-Based Guide, National Institute on Drug Abuse, National Institutes of Health, October 1999.

Excerpted from
Alcohol and Drug Abuse Division, Request for Proposals
Section 2, General Requirements:

Important Website Addresses

ADAD does not intend this reference to be an exhaustive list of substance abuse treatment Website addresses. APPLICANTS are encouraged to utilize additional resources should more information be needed. Please also note that Website addresses may change periodically.

I. ADAD-Related Regulations.

Code of Federal Regulations (CFR):
http://www.access.gpo.gov/nara/cfr/cfr-table-search.html

- **42 CFR Part 2** -- Confidentiality of Alcohol and Drug Abuse Patient Records
  www.access.gpo.gov/nara/cfr/waisidx_01/42cfrv1_01.html
- **45 CFR Part 96** -- Substance Abuse Prevention and Treatment Block Grants; Interim Final Rule
  www.access.gpo.gov/nara/cfr/waisidx_01/45cfr96_01.html

Public Law (P.L.):
http://www.access.gpo.gov/nara/nara005.html

- **P. L. 102-321 – Subpart II** Block Grants for Prevention and Treatment of Substance Abuse
  http://www.samhsa.gov/centers/csat/content/UBGAS/PLaw102.htm

Hawaii Revised Statutes (HRS):
www.capitol.hawaii.gov/site1/docs/docs.asp?press1=docs

- **Chapter 321, Title 19, HRS –** Department of Health (Index)
  http://www.capitol.hawaii.gov/hrscurrent/vol06_ch321-344/hrs321/hrs_321.htm
- **325-101 HRS** -- Confidentiality of HIV Records
  www.capitol.hawaii.gov/hrscurrent/Vol06_Ch321-344/hrs325/HRS_325-101.htm
- **328K HRS** -- Smoking
  www.capitol.hawaii.gov/hrscurrent/Vol06_Ch321-344/hrs328k/
- **Chapter 334 HRS** – Mental Health, Mental Illness, Drug Addiction, and Alcoholism (Index)
  http://www.capitol.hawaii.gov/hrscurrent/vol06_ch321-344/hrs334/hrs_334.htm
- **577 HRS** -- Adolescents and Confidentiality
  www.capitol.hawaii.gov/hrscurrent/Vol12_Ch501-588/hrs577/

Hawaii Administrative Rules (HAR), Department of Health
http://mano.icsd.hawaii.gov/doh/rules/ADMRULES.html

- **Title 11, Chapter 98 HAR** -- Special Treatment Facility License
  http://mano.icsd.hawaii.gov/doh/rules/11-98.pdf
- **Title 11, Chapter 175 HAR** -- Mental Health and Substance Abuse System
  http://mano.icsd.hawaii.gov/doh/rules/11-175.pdf

II. Government Resources

Hawaii

- **Alcohol and Drug Abuse Division** (ADAD), Department of Health
  http://www.hawaii.gov/health/resource/drug_abuse.html
- **Department of Commerce and Consumer Affairs**
  http://www.hawaii.gov/dcca/breg-seu/related.html

National

- **TIPs (Treatment Improvement Protocols)**
  http://www.kap.samhsa.gov
- **Addiction Technology Transfer Center** (ATTC), The Change Book
  www.nattc.org/thechangebook
- **Center for Substance Abuse Prevention** (CSAP), SAMHSA
  http://www.samhsa.gov/centers/csap/csap.html
- **Center for Substance Abuse Treatment** (CSAT), SAMHSA
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